# COVID-19 screening checklist

Race number

Body temperature*

| | | | |
|---|---|---|---|
| **Surname** | | **Name** | |
| **Identity number** | | **Age** | |
| **Contact number** | | **Gender** | |
| **Home address** | | | |
| **Signature** | | **Date** | |

Please read carefully and answer the following questions

| **Description** | **YES** | **NO** |
|---|---|---|
| Have you been in personal contact with anyone that has travelled outside SA in the past 21 days? | | |
| Are you under health investigation by Dept of Health or the National Institute for Communicable Diseases of South Africa (NICD)? | | |
| Have you had contact with a confirmed COVID19 positive person? | | |
| Have you had contact with a healthcare worker working at a hospital treating COVID19 persons? | | |
| Have you experienced any of the following symptoms?<br>Headaches<br>Difficulty breathing<br>Tightness of chest<br>Runny nose<br>Sneezing<br>Light headedness<br>Shortness of breath | | |
| Have you experienced any of the following symptoms?<br>• Persistent dry coughing<br>• Persistent fever of 38 degrees Celsius or more<br>• Body aches<br>• Loss of smell/Loss of taste<br>• Nausea<br>• Vomiting<br>• Diarrhoea<br>• Fatique/Weakness/Tiredness<br>• Dry Cough<br>• Sore throat<br>• Any respiratory-related problems<br>• Loss of smell (anosmia)<br>• Loss of taste (ageusia) | | |
| Do you have a household member with the above symptoms? | | |
| Have you been in close contact with anyone having any of the above symptoms? | | |
| Have you been diagnosed with pneumonia in the past 30 days? | | |
| Have you tested positive for COVID19 in the past?<br>If yes, you will need to provide a medical certificate confirming you do NOT have any active infection of COVID19 | | |

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|---|---|
| Checked by COVID19 Compliance Official (signature)* | |
| Date* | |

**To be completed by COVID-19 compliance officer*